April/May 2004

Insight

For benefits administrators

COBRA corner

COBRA letters updated

The Employee Insurance Program (EIP) has updated the sample COBRA notification letters and cover memo. The new versions are now available online at www.eip.sc.gov. Choose your category (Benefits Administrators), and then log on to the "Restricted Area Access." From there, the COBRA letters may be found under "Forms." They are available in both Microsoft Word and Adobe Acrobat pdf versions. **You must begin using these letters by June 1, 2004.**

Note that they are now listed separately on our Web site:
- COBRA Initial Notification Letter and cover letter;
- COBRA 18-Month Notification Letter;
- COBRA 36-Month Notification Letter.

Each notification letter includes a cover sheet that has helpful instructions for completing the letter. Please read the instructions first!

COBRA documentation reminder

Please remember to keep copies of the actual COBRA notification letters in your files, not just the COBRA notification cover memo. Failure to keep copies of the actual letters is an audit exception.

Medical Spending Accounts and COBRA

As a reminder, terminating employees may continue their MoneyPlu$ Medical Spending Accounts (MSAs), while on COBRA, as follows:

- They may continue their accounts *only through the end of the calendar year* in which they terminate employment, provided they have not already received reimbursements totaling their maximum election for the year. For example, if an employee, who elected to contribute $1,000 to a MSA, terminates employment and has only received reimbursements totaling $200, that employee may continue contributing to his MSA for the remainder of the year so that he may receive reimbursements for the remaining $800. He cannot re-enroll for the following calendar year.
- They must continue to remit their MSA contributions monthly. The contributions are paid on an *after-tax basis*, directly to Fringe Benefits Management Company, third-party administrator for the MoneyPlu$ program. If they fail to remit contributions in a timely manner, their coverage will end (the account will be cancelled) and any remaining balance will be forfeited.

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How the new Medicare-approved drug card affects EIP subscribers[1]

MEDICARE APPROVED SM

As a result of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Medicare has implemented a new discount card program for prescription drugs. The cards, to be provided by contracting companies, go into effect beginning June 2004. The cards are intended to help eligible Medicare beneficiaries with prescription drug costs until the permanent Medicare drug benefit begins in 2006.

Almost anyone eligible for Medicare, including Medicare beneficiaries enrolled in health insurance through EIP, may obtain a drug discount card. *Only those who have outpatient drug coverage through Medicaid are not eligible.* Medicare beneficiaries may begin signing up for a card this month. The discount card program is voluntary, and enrolling is up to the individual. However, below are some points to consider before enrolling.

- While a beneficiary can enroll in only one discount card at a time, there is no single Medicare-approved drug discount card. In South Carolina, there will be 20-30 different card programs from which to choose, each with its own covered drugs

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South Carolina
Budget and Control Board
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COBRA Corner

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TRICARE Supplement subscribers

Dental insurance

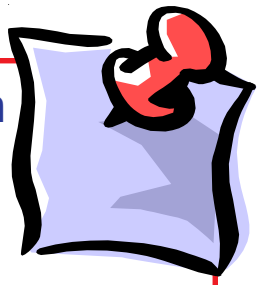
TRICARE Supplement subscribers have the same COBRA election rights for their dental coverage as all other State Dental Plan and Dental Plus subscribers. Normal COBRA notification procedures apply for dental insurance only.

Health insurance

Because the TRICARE Supplement plan is fully portable, subscribers terminating employment with the state who are still eligible for coverage under TRICARE can simply continue their plan directly through ASI. Because terminating TRICARE Supplement subscribers cannot continue health coverage through EIP, this coverage should not be included on the qualifying event letter or the Initial COBRA letter you send to them at the time of hire.

When dependents become ineligible for coverage under TRICARE, normal EIP COBRA procedures do not apply. Instead, the *Continued Health Care Benefit Program* (CHCBP), administered by Humana Military Healthcare Services, Inc. (HMHS), provides continuation coverage for TRICARE Supplement subscribers and their dependents. You should advise subscribers with dependents losing coverage under TRICARE that they will be contacted by HMHS regarding continuation coverage options. Additional information regarding CHCBP coverage is available online at www.tricare.osd.mil. Look for the drop-down menu for the TRICARE Handbook, and select "Loss of Benefits."

Local subdivisions: More on the experience rating



As announced in the last issue of *Insight*, health insurance premiums for optional employer groups will be increasing. *(Refer to the article, "Experience rating to take effect July 1, 2004," in the March 2004 issue.)* This increase is the result of experience rating, and the new rates for these groups will go into effect July 1, 2004. The Employee Insurance Program (EIP) does not anticipate another increase occurring mid-year; in the future, any increases should occur on a calendar-year basis.

If your group's rate is increasing less than five percent

Subscribers whose premiums will be increasing less than five percent may make no mid-year plan changes as a result of the experience rating. Their premiums will increase automatically. The MoneyPlu$ Pretax Group Insurance Premium feature, for those active subscribers who are currently participating, will also be adjusted automatically to cover the increase.

Please notify all of your subscribers—active employees, retirees, COBRA subscribers and survivors—regarding any increase in premiums.

If your group's rate is increasing five percent or more

In accordance with IRS guidelines and regulations regarding cafeteria plans, subscribers whose premiums will be increasing five percent or more as a result of their employer's experience rating will be allowed to change their health insurance coverage under certain conditions. Any changes would go into effect July 1.

Note: An employee transferring from another state covered entity to your entity in the future should be given the opportunity to make the same changes employees can make now due to the rate increase. They should be given a 31-day window from their hire date to make such changes.

EIP recently sent a letter to benefits administrators for employer groups affected by the rating and whose premiums are increasing at least five percent. Included with the letter is a list of the conditions under which subscribers may make changes to their health insurance coverage. The information in this list should be helpful in communicating what subscribers can and cannot do as a result of the mid-year increase.

To ensure accurate and timely processing, you should fill out Notice of Election forms (NOE) for employees making mid-year changes due to the rate increase as follows:

- If an employee is changing plans or dropping coverage due to the rate increase, write "Experience Rating" on the Other Changes line in section A of the NOE form.
- The NOE must be signed and dated by July 31, 2004.
- The effective date of the change should be July 1, 2004.

Please be sure to communicate this information to all of your subscribers—active employees, retirees, COBRA subscribers and survivors. If, for some reason, you did *not* receive this letter and list, but are expecting a mid-year increase of five percent or more, please contact Laura Smoak at lsmoak@eip.sc.gov.

Medicare-approved drug discount card

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and annual enrollment fee. The annual enrollment fee for a card may not exceed $30. This fee is charged, regardless of the time of year in which you enroll. Companies authorized to offer the discount cards must place a "Medicare-approved" seal on the card.

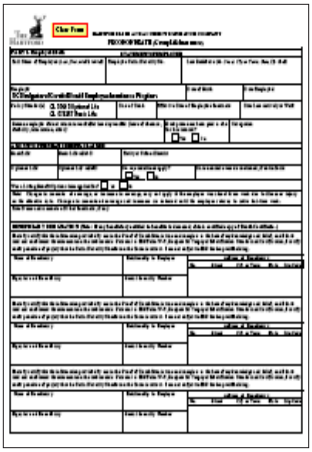
• The discount amount is a lower retail price; various companies decide which drugs will be offered at a discount and your cost for them. Only drugs included on the company's list will be discounted. Different drugs on this list may be discounted at different rates, and the discounted prices may change during the year. Therefore, you will need to compare carefully the prices you pay for your drugs under your health plan vs. a Medicare-approved card's prices to determine if a card may be beneficial to you.

• If you have a pharmacy that you use regularly to obtain your prescriptions, it is important to note that each discount card has a limited number of pharmacies that accept it. Participating pharmacies vary from card to card and may or may not participate in your EIP health plan's pharmacy network.

Although eligible for a Medicare-approved drug discount card, Medicare beneficiaries who participate in an EIP health insurance plan are *not* eligible for a low-income credit of $600 to help pay for prescription drugs, since all EIP health insurance plans offer prescription drug coverage. The credit is available only to Medicare beneficiaries who meet the income requirements and who do not have health insurance coverage that offers prescription drug coverage.

Medicare beneficiaries without prescription drug coverage must have individual incomes below $12,569 or combined incomes of less than $16,862 for married couples to qualify for the credit. Anyone who may be considering dropping insurance coverage under EIP simply to qualify for the $600 credit should think twice before doing so! Dropping health insurance means losing coverage not only for prescription drugs, but also for medical care, hospitalization, physician visits and much more.

Medicare beneficiaries who opt for a Medicare-approved drug discount card will need to compare carefully and choose the card that best fits their needs. A comparison of cards offered is posted on the official Medicare Web site at http://www.medicare.gov. You can type in your zip code and see the drug prices and services offered by each sponsor in your area. You may also call 800-633-4227 for similar information.



Proof of Death Form update

Several benefits administrators (BAs) brought it to the attention of the Employee Insurance Program (EIP) that the Proof of Death Form available on our Web site was not working properly. The malfunctioning data entry fields have been fixed and the updated form is now available through the BA section of EIP's Web site at www.eip.sc.gov.

We at EIP appreciate the assistance of BAs in keeping our Web site in good working order.

Benefits at Work

2004

Benefits at Work Conference 2004

The Employee Insurance Program (EIP) invites you to its annual "Benefits at Work" (BAW) conference, August 30 - September 2, 2004. The Embassy Suites Hotel (Columbia) will host the conference.

- Public Schools - Monday, August 30
- State Agencies - Tuesday, August 31
- Local Subdivisions - Wednesday, September 1
- Higher Education/Local Subdivisions - Thursday, September 2

Registration

You will soon receive your registration packet via e-mail (those who do not have an active e-mail address on file will receive a copy in the mail). However, you can begin making your hotel reservation with the Embassy Suites Hotel immediately. Call 803-252-8700 or 800-EMBASSY (362-2779). Be sure to reference the "Benefits at Work" conference so that you will receive the discount rate of **$99 for a double or king room**. The deadline to make your reservations to receive the discounted room rate is **Thursday, July 29**. If you have any questions, your contact person at the Embassy Suites is Teri Pringle.

Should you have any questions about the conference, call Pamala Jackson at 803-734-0706 (or toll-free at 1-888-260-9430) or send her an e-mail: pjackson@eip.sc.gov.

Accident Questionnaires

When State Health Plan (SHP) subscribers report accident-related claims, BlueCross BlueShield of South Carolina (BCBSSC) needs information about the event. They gather this information through an Accident Questionnaire (AQ) that the subscriber completes. These AQs are sent to subscribers when there is a claim filed for treatment of an injury or diagnosis that has been established by BCBSSC's staff of physicians as likely to be accident or work-related. AQs are generated once per week, based on the claims that were received that week. Some subscribers receive multiple AQs related to the same event, which can be confusing. Below are some reasons why this might happen, along with the best way to resolve each of them.

One possibility is that BCBSSC may simply not have received a response to the first AQ they sent. Since AQs are generated weekly, it is possible that a subscriber may not have sufficient time to respond to the first one they received before a second is generated. The subscriber should not receive more than one extra AQ if they return the first one in a timely manner. Additional AQs will be sent to the subscriber each week until BCBSSC receives a completed AQ. To help eliminate the extra cost and inconvenience of receiving AQ forms, subscribers should complete and return them in a timely manner.

Subscribers may also receive more than one AQ if more than one covered person in the same family receives treatment related to the same accident. In this situation, BCBSSC will send out an AQ for each covered individual being treated for injuries related to the accident. To distinguish among the different AQs, BCBSSC lists the name of the patient for whom a particular AQ has been generated at the top of the questionnaire. Subscribers should answer and return promptly an AQ for each covered individual being treated for injuries related to the accident.

Once BCBSSC receives an AQ response, it is valid for six months. If claims meeting the established accident-related criteria are reported more than six months after the original accident date, the subscriber will receive another AQ. This six-month cycle helps BCBSSC identify any subsequent accidents that may have occurred. If claims reported more than six months after the original accident are related to that event, the subscriber should simply check the "update" space and return the questionnaire to BCBSSC. This will update the subscriber's file for another six months.

BCBSSC is working on improvements to its computer systems that will help to prevent duplicate AQs from being generated and sent to subscribers. In the next few months, new procedures will limit the number of AQs generated for each subscriber to one per month in order to give subscribers more time to respond.

Get to know the Travel Assistance Program

The Hartford offers a Travel Assistance program to all Basic and Optional Life Insurance subscribers and their dependents through Worldwide Assistance Services, Inc. (WA). Through this program, subscribers and their covered dependents traveling 100 or more miles from home for up to 31 consecutive days can get pre-trip information services while planning their trips and emergency assistance if they need it while traveling.

Recently, some subscribers have been confused about what information they will need to provide in order to access these services. Because the Travel Assistance Program is provided through WA rather than directly through the Hartford, the ID number for this program is different from the Hartford Life Insurance group policy numbers. As listed on your travel assistance card, your WA ID number is **GLD-09012**. The Hartford group policy number for Basic Life subscribers is **GL674267** and for Optional Life subscribers is **GL33913**. When you call to access your travel assistance benefits through WA, you will need to provide both the WA ID number and your Hartford Life Insurance group policy number. You may find it helpful to write your group policy number in indelible ink in the space provided for it on your travel assistance card.

For more information on the Travel Assistance Program, including a complete checklist of information you will need when accessing these benefits, consult your *2004 Insurance Benefits Guide* or log on to the Worldwide Assistance Services Web site at www.worldwideassistance.com.

How do I get new identification cards?

If you do not have an identification card to verify that you are a member of one of the health or dental plans offered through the Employee Insurance Program (EIP), you may have trouble accessing benefits. That's why it is so important that each person covered under the State Dental Plan (SDP), Dental Plus, State Health Plan (SHP), TRICARE Supplement or one of the HMOs have an identification card. It is not uncommon for cards to be misplaced, stolen or simply not delivered to all covered members. Below are instructions for requesting one or more ID cards for each health and dental plan.

SHP

If you need new SHP ID cards, it's easy to order them using the "Request for BlueCross and BlueShield Card Form." Just log onto the Employee Insurance Program (EIP) Web site at www.eip.sc.gov and choose your category; click on "Forms." Scroll down and click on "Request for Blue Cross and Blue Shield Card (SHP ID Card)." Once you have filled in all of the necessary information, just drop the form in the mail to BlueCross BlueShield of South Carolina (BCBSSC) (The full address is listed on the form). Your new ID card(s) will be delivered in about two weeks.

Companion HMO and MUSC Options

Companion HMO and MUSC Options subscribers can request new ID cards through Companion's Web site. Just visit EIP's Web site at www.eip.sc.gov and click on "Insurance Managers." From the Insurance Managers list, choose "Companion Healthcare (health and prescription drugs)/MUSC Options (health)." Once you've reached the Companion Healthcare Web site, click on "Go there now…" under the section called "My Insurance Manager." From there, just log in with your Username and Password and select "Request an ID Card."

CIGNA

CIGNA subscribers can request a new ID card online by visiting the EIP Web site at www.eip.sc.gov and clicking on "Insurance Managers." Choose "CIGNA Healthcare (health and prescription drugs)." Once you reach the CIGNA Web site, you can log in and choose "Request Medical ID Card" to reach the ID card request form. If you do not have a username and password, you can choose "Go to CIGNA.com" and select "Important Forms" from the "Popular Links" menu. Scroll down and click on "Request a CIGNA Healthcare ID Card," then fill in all the requested information.

TRICARE Supplement

Subscribers to the TRICARE Supplement Plan should call the Association & Society Insurance Corporation (ASI) customer service line at 800-638-2610, extension 255, to request a new ID card. New cards are typically shipped within 24 hours of the request.

State Dental Plan and Dental Plus

If you need new SDP cards, call your benefits administrator (BA) first to find out if he/she has any extras set aside. If your BA does not have any SDP ID cards available, contact Judy Looney with BCBSSC by phone at 800-868-2500, extension 43462, or by e-mail at judy.looney@bcbssc.com. Dental Plus members should call BCBSSC Customer Service at 888-214-6230 to request new ID cards.

Most plan administrators also take new ID card requests over their customer service lines. Health and dental insurance cards are issued by the individual plan administrators rather than EIP, so additional questions should be directed to those companies. Contact information for each administrator may be found in the back of your 2004 *Insurance Benefits Guide.*

Long Term Care reminders

Who can enroll and when?

Full-time permanent employees can enroll:

- Within 31 days of hire, without medical evidence of good health
- Anytime, with medical evidence

Retired employees and surviving spouses can enroll:

- Anytime, with medical evidence

Spouses of eligible employees or retirees can enroll:

- Anytime, with medical evidence, whether or not the employee/retiree is enrolled

Note: There is a 10 percent discount in premiums for the employee/retiree and spouse if they both are enrolled in the Service Reimbursement Plans. The discount is not automatic! Contact your benefits administrator for details.

Parents and parents-in-law of eligible employees can enroll:

- Anytime, with medical evidence, whether or not the employee is enrolled

Whom do I contact about LTC?

Contact EIP for:

- New enrollment information and questions
- Retirement/termination (status changes, confirm dates and set up billing)
- Confirm effective date of coverage (employee and spouse)
- Premium rates
- Information on premium deductions from retirement checks

Contact Aetna for:

- Enrollment kits/policy information
- Application status for underwritten applications
- Policy information for parents/in-laws
- Claim processing/information
- All direct-billed employees and retirees

South Carolina Budget and Control Board
Employee Insurance Program
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When retirees return to work

When retirees return to permanent, full-time employment, they have the opportunity to change their level of benefits. These working retirees have the option of maintaining their retiree status or changing to active status and receiving the same level of benefits as all other active employees.

As the benefits administrator, you should advise returning retirees that refusing active subscriber status will make them ineligible for all the benefits available to them as active employees, including the $3,000 Basic Life Insurance benefit, Basic and Supplemental Long Term Disability coverage, Dependent Life and/or Optional Life Insurance and MoneyPlu$. You must also remind retirees who **do** choose to return to coverage as active employees and elect Dependent Life and/or Optional Life Insurance that they have to terminate their portability or conversion of retiree policies through the Hartford.

Retirees who wish to refuse active subscriber status, must sign an "Active Group Benefits Refusal Form." Signing this form certifies that returning retirees understand exactly what benefits they are refusing. Once the form is signed and returned to you, mail the original to the Employee Insurance Program and make a copy to keep for your records.

Insight

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